TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
CORPUS CHRISTI MEDICAL CENTER

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-15-3945-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
August 6, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It is our assertion that the submitted information will prove that the care provided met inpatient criteria should be reviewed for reconsideration. The facility provides care to your member at the direction of the attending physician with coordination of benefits per your representative and, in turn, expects reimbursement for serviced rendered."

Amount in Dispute: $114,370.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor has waived its right to DWC MDR. No payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 23, 2014 through August 8, 2014	Inpatient Facility Charges	$114,370.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-197 – Precertification/authorization/notification absent
   - 930 – Preauthorization required, reimbursement denied

Issues

1. Did the requestor waive the right to medical fee dispute resolution?
2. Did the requestor obtain preauthorization per 28 Texas Administrative Code §134.600 (p) (1)?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier in their position summary states, "One year from disputed date 8/4/14 is 8/4/15. The TDI/DWC date stamp lists the received date as 8/6/15 on the requestor's DWC-60 packet, a date greater than one year from 8/4/14. The requestor has waived its right to DWC MDR."

   28 Texas Administrative Code §133.307(c) (1) states, "Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute."

   The requestor seeks reimbursement for an inpatient admission for dates of service July 23, 2014 through August 8, 2014. The date of discharge for the inpatient services is August 8, 2014. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on August 6, 2015. Therefore, the dispute was filed timely to MDR and eligible for review. The Division concludes that the requestor has timely filed this dispute with the Division's MFDR Section; as a result, the disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. The requestor seeks reimbursement for inpatient services, as identified on the bill with type of bill 111, for charges rendered on July 23, 2014 through August 8, 2014. The insurance carrier denied the disputed charges with claim adjustment reason codes "CAC-197 – Precertification/authorization/notification absent" and " 930 – Preauthorization required, reimbursement denied."

   28 Texas Administrative Code §134.600 (p) states in pertinent part, "... health care requiring preauthorization includes: (1) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay..." Review of the submitted information finds that the requestor submitted insufficient documentation to support that the disputed inpatient services were preauthorized pursuant to 28 Texas Administrative Code §134.600 (p)(1). As a result, reimbursement for the disputed services cannot be recommended.

3. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution. This findings and decision is based upon a review of all the evidence presented by the parties in this dispute. Even though not all the evidence was discussed, it was considered. The Division finds that the insurance carrier's denial reason is supported and therefore, reimbursement cannot be recommended to the requestor for the disputed services rendered on July 23, 2014 through August 8, 2014.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		November 4, 2015
Signature	Medical Fee Dispute Resolution Officer	Date
		November 4, 2015
Signature	Health Care Business Management Director	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.